



EAR, NOSE & THROAT CONSULTANTS OF NEVADA

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I authorize for Ear, Nose & Throat to release Medical records to the following Medical Providers.

Doctors or Facility Name _____ Phone # _____ Fax # _____

Doctors or Facility Name _____ Phone # _____ Fax# _____

Per My Permission-Leave Medical Information on my answering machine-

YES NO

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to Medical Records Department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtain from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify a date, **this authorization will expire one (1) year from the signature on this form.**

Signature of Patient Date _____

Signature of Guardian or Personal Representative Date _____

Patient number

Northwest Office
7040 Smoke Ranch Road
Las Vegas, NV 89128

Green Valley Office
3195 St Rose Parkway
Suite 210
Henderson, NV 89052
(Mailing address)

Southwest Office
8840 W Sunset Road
Suite A
Las Vegas, NV 89148